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Now is the Time to Prepare for the No Surprises Act

The Federal No Surprises Act ("the Act") will go into effect for healthcare providers and health plans beginning January 1, 2022. With an eye toward protecting patients from unexpected out-of-network medical costs, this law will require payers and providers to interact and negotiate in new ways. Health care providers and health care facilities should begin preparations now for implementing the requirements of the Act.

Basics of the Act

The No Surprises Act applies to out-of-network healthcare providers who provide (1) emergency services, including emergency departments, ambulance, and air ambulance; (2) post-stabilization services such as in-patient hospital services; and (3) other medical services at an in-network facility. Out-of-network providers in these situations will now be required to submit a claim for services to the patient's health plan. The only exception to this claim submission requirement is for out-of-network provider services that are not ancillary services where the provider provides the patient notification of the out-of-network cost and obtains consent to proceed out-of-network.

The health plan is required to process the claim and notify the out-of-network provider of a denial or make a minimum payment to the provider. The health plan is required to calculate the patient's out-of-pocket costs for the service at the in-network rate based on the all-payer model agreement rate, state-determined rate, or, if neither the all-payer nor state-determined rate apply, then the health plan's median contracted payment rate for the service.

Upon receipt of the payment from the health plan, the out-of-network provider is prohibited from billing the patient for more than the calculated in-network costshare. If the provider is not willing to accept the minimum payment amount from the health plan, then the provider can negotiate with the health plan or initiate an independent dispute resolution ("IDR") process. This IDR process is a baseball-style arbitration with an entity certified by CMS. Each party must submit a proposed payment amount and the IDR entity must select one amount. The IDR rate determination is binding on the parties.

There are several steps that health care providers and health care facilities should be taking now to prepare for the No Surprises Act:

Public Notice Requirements

Healthcare providers and facilities are required to provide notice to certain consumers of the obligations of the provider or facility and the related patient rights under the Act. Only health care providers that furnish items or services in a health care facility are required to provide the notice, and only to individuals who received such items or services at a health care facility or in connection with visits at a health care facility. Those providers and facilities who are required to give notice should begin preparing the notices and establishing procedures to assure the notices are properly posted and provided to individuals.

Content of the Notice

The notice must include the following:

- A statement that explains the requirements of, and prohibitions applicable to, the health care provider or health care facility under the No Surprises Act.
- If applicable, a statement that explains any state balance billing laws.
- A statement providing contact information for the appropriate federal (and, if applicable, state) agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice.

How Notice Is Provided

- The notice must be posted on (or linked on the homepage of) the health care facility's or provider's website (if it has a website).

- The notice must also be prominently posted on a sign at the location of the facility or provider (if the provider has a publicly accessible location).
- The notice must be provided to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer. This notice to individuals must be in a one-page (double-sided) notice, using print no smaller than 12-point font. It must be provided in person or through mail or email, as selected by the individual.
- A provider who furnishes items or services at a facility may enter into a written agreement with the facility for the facility to assume the obligation to provide notice at the facility location and the obligation to provide notice to the individuals receiving care at the facility. When such a written agreement is in place, any violation of the regulatory notice requirements falls on the facility.

Timing of Notice

Website and location notices should be posted on January 1, 2022. The notice to individuals must be provided:

- No later than the date and time on which the provider or facility requests payment from the individual, or
- If the provider or facility does not request payment from the individual, then no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer.

Other Preparations for Implementation of the Act

- Health care providers who render emergency medical services or ancillary or other post-stabilization services at a health care facility should evaluate which out-of-network health plans cover patients in the community, implement a process for submitting claims to such health plans, and gather information regarding standard payment rates by which the provider can assess the payment received from the health plan and support the IDR process where necessary.
- Health care providers and facilities should evaluate the extent to which a provider who is involved in the provision of a service may be out-of-network

when the facility is in-network. To the extent that these services are ancillary (e.g. radiology, anesthesia, pathology, etc.) or the provider is not the only provider of the service at the facility, the out-of-network provider will be subject to the Act. If the services are not ancillary services or furnished by only one provider at the facility and the out-of-network provider desires to balance bill the patient, then the out-of-network provider and facility should coordinate how to provide the patient with notice of the out-of-network status and obtain consent to proceed with the service.

This blog post was drafted by Laura Bond and Stacy Harper, attorneys in the Spencer Fane Overland Park, KS office. In addition to this blog, Stacy Harper will be hosting an educational webinar to discuss this topic in more detail on Wednesday, December 8 from 12:00pm – 1:00pm CT. For more information, visit www.spencerfane.com, and to register for the webinar, please click here.